

ORIGINALFILED
MAY 27 2008
U.S. DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

COMPLAINT BY A PRISONER UNDER THE CIVIL RIGHTS ACT, 42 U.S.C §§ 1983

Name TURNER, LEONARD

(Last)

(First)

(Initial)

Prisoner Number T-70330Institutional Address CSP Solano State PrisonPO BOX 4000 Vacaville CA 95696UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIATURNER, LEONARD

(Enter the full name of plaintiff in this action.)

vs.

Sgt RODGERS C/SGT
Individually and in
his official Capacity

(Enter the full name of the defendant(s) in this action)

CV 08**2648**

Case No. _____

(To be provided by the clerk of court)

COMPLAINT UNDER THE
CIVIL RIGHTS ACT,
42 U.S.C §§ 1983**MMC****(PR)**

[All questions on this complaint form must be answered in order for your action to proceed..]

I. Exhaustion of Administrative Remedies

[Note: You must exhaust your administrative remedies before your claim can go forward. The court will dismiss any unexhausted claims.]

A. Place of present confinement CSP Solano Prison

B. Is there a grievance procedure in this institution?

YES (✓) NO ()

C. Did you present the facts in your complaint for review through the grievance procedure?

YES (✓) NO ()

D. If your answer is YES, list the appeal number and the date and result of the appeal at

COMPLAINT

- 1 -

each level of review. If you did not pursue a certain level of appeal, explain why.

1. Informal appeal By pass

2. First formal level By pass

3. Second formal level By pass

4. Third formal level Director of Corrections

P.O. Box 942893

SACRAMENTO, CA 94293-0001

E. Is the last level to which you appealed the highest level of appeal available to you?

YES (✓) NO ()

F. If you did not present your claim for review through the grievance procedure, explain

why.

II. Parties

A. Write your name and your present address. Do the same for additional plaintiffs, if any.

TURNER, LEONARD T-70330

CSP Solano State Prison

P.O. Box 4000 Vacaville Ca 95696

B. Write the full name of each defendant, his or her official position, and his or her place of employment.

Sgt Rodgers CSP Solano State Prison

P.O. Box 4000 Vacaville Ca 95696

COMPLAINT

III. Statement of Claim

State here as briefly as possible the facts of your case. Be sure to describe how each defendant is involved and to include dates, when possible. Do not give any legal arguments or cite any cases or statutes. If you have more than one claim, each claim should be set forth in a separate numbered paragraph.

On 1-17-08 I was returning from medical c/o Nixon stop me search me and took me into Program Complex accusing me of being out of bounds. I then showed my medical card to Sgt Rodgers I received 0700 1300, 1700 meds Sgt Rodgers then stuff me in security Box 264 7ft for 2 hrs I showed him my medical clearance stating I suffer from phantom limb, leg and arm prosthesis and am ADA American Disability Act I wear a mobility vest he totally disregards my medical issue And I have copies of all medical records, And due to that situation I'm now in constant pain

IV. Relief

Your complaint cannot go forward unless you request specific relief. State briefly exactly what you want the court to do for you. Make no legal arguments; cite no cases or statutes.

I want to be compensated for pain and suffering his wages garnished, clean on all real property life time medical compensatory damages & punitive damages in the amount

1 I'm also asking for 700,000 for pain & suffering
2
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4 I declare under penalty of perjury that the foregoing is true and correct.
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6 Signed this 29th day of April, 2008
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8 Leonard Turner
9 (Plaintiff's signature)
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(C.C.P. §§445; 2015.5;
28 U.S.C. §1746)

I, LEONARD TURNER, declare under the penalty of perjury that:

am the PERSON T-20330 in the attached matter; I have read the foregoing document(s) and know the contents thereof; and the same is true of my own personal knowledge, or upon information and belief therein that they are true; that if called to testify as to the contents hereof I could do so competently as a sworn witness.

Executed this 29th day of April, 08, at California State Prison / Solano, Vacaville, California.

(Signature)

Leonard Turner
Declarant

DECLARATION OF SERVICE BY MAIL

(C.C.P. §§1013(a); 2015.5; 28 U.S.C. §1746)

I, _____, declare: That I am a resident of California State Prison / Solano, State of California; I am over the age of 18 years; I am/am not a party to the above entitled action; My address is P.O. Box 4000 _____, Vacaville, CA 95696. I served the attached document(s) entitled:

on the persons/parties specified below by placing a true and duplicated copy of said documents into a sealed envelope with appropriate First Class Postage affixed thereto and prepaid, and placing said envelope(s) into the United States Mail in a deposit box provided at the California State Prison / Solano, in Vacaville, California, addressed as follows:

There is First Class mail delivery service by United States Mail at the places so addressed and/or regular communication by mail between the place of mailing and the addresses above. I declare under the penalty of perjury that the foregoing is true and correct and that I executed this service on this _____ day of _____ at California State Prison / Solano, in Vacaville, California.

(Signature) _____

Declarant

**UNITED STATES CODE SECTIONS
UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA**

TITLE 28 UNITED STATES CODE

§ 2241. POWER TO GRANT WRIT

(a) Writs of habeas corpus may be granted by the Supreme Court, any justice thereof, the district courts and any circuit judge within their respective jurisdictions. The order of a circuit judge shall be entered in the records of the district court of the district wherein the restraint complained of is had.

(b) The Supreme Court, any justice thereof, and any circuit judge may decline to entertain an application for a writ of habeas corpus and may transfer the application for hearing and determination to the district court having jurisdiction to entertain it.

(c) The writ of habeas corpus shall not extend to a prisoner unless--

(1) He is in custody under or by color of the authority of the United States or is committed for trial before some court thereof; or

(2) He is in custody for an act done or omitted in pursuance of an Act of Congress, or an order, process, judgment or decree of a court or judge of the United States; or

(3) He is in custody in violation of the Constitution or laws or treaties of the United States; or

(4) He, being a citizen of a foreign state and domiciled therein is in custody for an act done or omitted under any alleged right, title, authority, privilege, protection, or exemption claimed under the commission, order or sanction of any foreign state, or under color thereof, the validity and effect of which depend upon the law of nations; or

(5) It is necessary to bring him into court to testify or for trial.

(d) Where an application for a writ of habeas corpus is made by a person in custody under the judgment and sentence of a State court of a State which contains two or more Federal judicial districts, the application may be filed in the district court for the district wherein such person is in custody or in the district court for the district within which the State court was held which convicted and sentenced him and each of such district courts shall have concurrent jurisdiction to entertain the application. The district court for the district wherein such an application is filed in the exercise of its discretion and in furtherance of justice may transfer the application to the other district court for hearing and determination.

**UNITED STATES CODE SECTIONS
UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA**

§ 2242. APPLICATION

Application for a writ of habeas corpus shall be in writing signed and verified by the person for whose relief it is intended or by someone acting in his behalf.

It shall allege the facts concerning the applicant's commitment or detention, the name of the person who has custody over him and by virtue of what claim or authority, if known.

It may be amended or supplemented as provided in the rules of procedure applicable to civil actions.

If addressed to the Supreme Court, a justice thereof or a circuit judge it shall state the reasons for not making application to the district court of the district in which the applicant is held.

 **ORIGINAL**

EXHIBIT COVER PAGE:

Exhibit: A

Description of this exhibit:

Number of pages of this exhibit: _____ pages

JURISDICTION: (Check only one)

____ Municipal Court

____ Superior Court

____ Appellate Court

____ State Supreme Court

____ United States District Court

____ United States Circuit Court

____ United States Supreme Court

____ California Department of Corrections, 602 Exhibit.

____ Other: _____

Inmate Medical Activity Card

NAME: TURNER T-20330

is authorized to: DOT MEDS

090, 130, 190

ISSUE DATE: 1/9/08 EXP DATE: 2/1/08

Medical Staff: DR WIN / RAL KAMMANN

PRIMARY CLINIC

ORIGINAL

Melina J Burns
PO Box 1587
Oakland CA 94604

Michael J Burns
Seyfarth Shaw LLP
560 Mission St #310
San Francisco CA 94105

2

① John Burris ^{#1120}
7677 Oakport St
94621

② Maureen Ellen Burns
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Sacramento 95825

John Stephen Burns
Law office
The McClatchy Co 2100 Q
PO Box 15779
Sacramento CA
95814



 **ORIGINAL**

EXHIBIT COVER PAGE:

Exhibit: B

Description of this exhibit:

Number of pages of this exhibit: _____ pages

JURISDICTION: (Check only one)

____ Municipal Court

____ Superior Court

____ Appellate Court

____ State Supreme Court

____ United States District Court

____ United States Circuit Court

____ United States Supreme Court

____ California Department of Corrections, 602 Exhibit.

____ Other: _____

ORIGINAL

DEPARTMENT OF CORRECTIONS

COMPREHENSIVE ACCOMMODATION CHRONO

INSTRUCTIONS: A physician shall complete this form if an inmate requires an accommodation due to a medical condition. Circle P if the accommodation is to be permanent, or T if the accommodation is to be temporary. If the accommodation is temporary, write the date the accommodation expires on the line. A new form shall be generated when a change to an accommodation is required or upon renewal of a temporary accommodation. Any new form generated shall include previous accommodations, if they still apply. Chronos indicating permanent accommodations shall be reviewed annually. This form shall be honored as a permanent chrono at all institutions.

A. HOUSING

None		<u>Bottom Bunk</u>	P/T
Barrier Free/Wheelchair Access	P/T	Single Cell (See 128-C date: _____)	P/T
Ground Floor Cell	P/T	Permanent OHU / CTC (circle one)	P/T
Continuous Powered Generator	P/T	Other _____	P/T

B. MEDICAL EQUIPMENT/SUPPLIES

None		Wheelchair: (type) _____	P/T
Limb Prosthesis	P/T	Contact Lens(es) & Supplies	P/T
Brace	P/T	Hearing Aid	P/T
Crutches	P/T	Special Garment:	
Cane: (type) _____	P/T	(specify) _____	P/T
Walker	P/T	Rx. Glasses: _____	P/T
Dressing/Catheter/Colostomy Supplies	P/T	Cotton Bedding	P/T
Shoe: (specify) _____	P/T	Extra Mattress	P/T
Dialysis Peritoneal	P/T	Other _____	P/T

C. OTHER

None		Therapeutic Diet: (specify) _____	P/T
Attendant to assist with meal access and other movement inside the institution.	P/T	Communication Assistance	P/T
Attendant will not feed or lift the inmate/patient or perform elements of personal hygiene.		Transport Vehicle with Lift	P/T
Wheelchair Accessible Table	P/T	Short Beard	P/T
		Other _____	P/T

D. PHYSICAL LIMITATIONS TO JOB ASSIGNMENTSBased on the above, are there any physical limitations to job assignments? ☒ Yes ☐ NoIf yes, specify: No standing more than 5 minutes continuously @ work
Perm

INSTITUTION <u>56</u>	COMPLETED BY (PRINT NAME) <u>Coyne</u>	TITLE
SIGNATURE <u>[Signature]</u>	DATE <u>12/29/06</u>	CDC NUMBER, NAME (LAST, FIRST, MI) AND DATE OF BIRTH <u>T 70330</u> <u>TURNER</u>
HCM/CMO SIGNATURE	DATE	
(CIRCLE ONE) <u>APPROVED</u> / DENIED		

**COMPREHENSIVE ACCOMMODATION
CHRONO**

Distribution:

 **ORIGINAL**

EXHIBIT COVER PAGE:

Exhibit: C

Description of this exhibit:

Number of pages of this exhibit: _____ pages

JURISDICTION: (Check only one)

____ Municipal Court

____ Superior Court

____ Appellate Court

____ State Supreme Court

____ United States District Court

____ United States Circuit Court

____ United States Supreme Court

____ California Department of Corrections, 602 Exhibit.

____ Other: _____

STATE OF CALIFORNIA
DISABILITY PLACEMENT PROGRAM VOL
DC 1845 (Rev. 01/04)

ATION (DPPV)

ORIGINAL

DEPARTMENT OF CORRECTIONS
CHECK ALL APPLICABLE BOXES

THIS FORM ONLY VERIFIES OR DISCONFIRMS CLAIMED PHYSICAL DISABILITIES LISTED IN SECTION B

INMATE NAME: TURNER CDC NUMBER: T70330 INSTITUTION: FSP HOUSING ASSIGNMENT: BJAATA 034 DATE FORM INITIATED: 5/31/07

Sections A - B to be completed by licensed medical staff.

SECTION A: REASON FOR INITIATION OF FORM		SECTION B: DISABILITY BEING EVALUATED	
<input type="checkbox"/> Inmate self-identifies to staff	<input checked="" type="checkbox"/> Third party evaluation request	<input type="checkbox"/> Blind/Vision Impaired	<input type="checkbox"/> Speech Impaired
<input type="checkbox"/> Observation by staff	<input type="checkbox"/> Medical documentation or Central File information	<input type="checkbox"/> Deaf/Hearing Impaired	<input checked="" type="checkbox"/> Mobility Impaired

Sections C - G to be completed by a physician only.

SECTION C: PERMANENT DISABILITIES IMPACTING PLACEMENT	SECTION D: PERMANENT DISABILITIES NOT IMPACTING PLACEMENT
<input type="checkbox"/> FULL TIME WHEELCHAIR USER - DPW Requires wheelchair accessible housing and path of travel.	1. NO CORRESPONDING CATEGORY
<input type="checkbox"/> INTERMITTENT WHEELCHAIR USER - DPO Requires lower bunk, wheelchair accessible path of travel and <i>does not require</i> wheelchair accessible cell.	2. NO CORRESPONDING CATEGORY
<input type="checkbox"/> MOBILITY IMPAIRMENT - With or Without Assistive Device (Wheelchairs shall not be prescribed) - DPM Orthopedic, neurological or medical condition that substantially limits ambulation (cannot walk 100 yards on a level surface without pause). Requires lower bunk, no triple bunk, and no stairs in path of travel.	3. <input checked="" type="checkbox"/> MOBILITY IMPAIRMENT (Lower Extremities) - DNM Walks 100 yards without pause with or without assistive devices. <input checked="" type="checkbox"/> No-Housing Restrictions <input checked="" type="checkbox"/> See HOUSING RESTRICTIONS in Section E <input type="checkbox"/> Requires relatively level terrain and no obstructions in path of travel. <i>Do not place at:</i> CCI, CMC-E, CRC, CTF-C, FSP, SAC, SCC I or II, SOL, or SQ. (CDC 128-C: _____)
4. <input type="checkbox"/> DEAF/HEARING IMPAIRMENT - DPH Must rely on written communication, lip reading or signing as residual hearing, with assistive devices, will not enable them to hear, understand or localize emergency warnings or public address announcements.	4. <input type="checkbox"/> HEARING IMPAIRMENT - DNH With residual hearing at a functional level with hearing aid(s).
5. <input type="checkbox"/> BLIND/VISION IMPAIRMENT - DPV Not correctable to central vision acuity of better than 20/200 with corrective lenses in at least one eye (See HOUSING RESTRICTIONS IN SECTION E).	5. NO CORRESPONDING CATEGORY
6. <input type="checkbox"/> SPEECH IMPAIRMENT - DPS Does not communicate effectively speaking or in writing.	6. <input type="checkbox"/> SPEECH IMPAIRMENT - DNS Does not communicate effectively speaking, but does when writing.

SECTION E: ADDITIONAL MEDICAL INFORMATION

CSRALERT:

- ☐ Requires relatively level terrain and no obstructions in path of travel
☐ Complex medical needs affecting placement ☐ CDC 128-C _____

HEALTH CARE APPLIANCE / IDENTIFICATION VEST:

- ☐ Cane ☐ Crutch ☐ Walker ☐ Leg/Arm prosthesis ☐ Vest
☐ Other: _____ ☐ CDC 128-C(s) dated: _____

ASSISTANCE NEEDED WITH ACTIVITIES OF DAILY LIVING:

- ☐ Feeding or Eating ☐ Bathing ☐ Grooming ☐ W/C transferring
☐ Toileting ☐ Other: _____ ☐ CDC 128-C(s) dated: _____

OTHER DPP DESIGNATIONS:

- ☐ NONE
CODE DATED CODE DATED

HOUSING RESTRICTIONS:

- ☒ Lower bunk ☐ No stairs ☐ No triple bunk. CDC 128-C(s) dated: 5/31/07

SECTION F: EXCLUSIONS

- ☐ VERIFICATION OF CLAIMED DISABILITY NOT CONFIRMED: My physical examination or other objective data DOES NOT SUPPORT *claimed* disability. (Explain in Comments Section and CDC 128-C dated _____).
☐ REMOVAL FROM A DPP CODE: Removal from previous DPP code: _____. (Explain in Comments Section and CDC 128-C dated: _____).
☐ REMOVAL FROM ENTIRE PROGRAM: Removal from DPP code(s): _____. (Explain in Comments Section and CDC 128-C dated: _____).

SECTION G: EFFECTIVE COMMUNICATION FACTORS

- ☐ Uses Sign Language Interpreter (SLI) ☐ Reads Braille ☐ Communicates with written notes ☐ Requires large print or magnifier
☐ Reads lips ☐ NO "EFFECTIVE COMMUNICATION" ISSUES OBSERVED OR DOCUMENTED IN THE UNIT HEALTH RECORD

PHYSICIAN'S COMMENTS: (Focus on affected systems and functional limitations. No specific diagnosis or other confidential medical information.)

Armed and dangerous. History of mental illness. History of self-harm and suicidal ideation. History of substance abuse. History of violence. History of sexual assault. History of sexual harassment. History of sexual abuse. History of sexual exploitation. History of sexual coercion. History of sexual harassment. History of sexual abuse. History of sexual exploitation. History of sexual coercion.

PHYSICIAN'S NAME (Print) <u>S. Reddy</u>	PHYSICIAN'S SIGNATURE <u>S. Reddy</u>	DATE SIGNED <u>5/31/07</u>
HEALTH CARE MANAGER'S / DESIGNEE'S NAME (Print) <u>BURRO MARRAS</u>	HEALTH CARE MANAGER'S / DESIGNEE'S SIGNATURE <u>B. Marras</u>	DATE SIGNED <u>6-4-07</u>

For the UHP, send the inmate copy via institutional mail.

LEONARD Turner T-70330
CSP Solano State Prison
PO Box 4000

CSP SOLANO
STATE PRISON



02 1A
0004622581



\$ 00.590

MAILED FROM ZIP CODE 95607



United State District

Northern District of C

301 Clay st